STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075079	A. Building B. Wing	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norwich Sub-Acute and Nursing	93 West Town Street Norwich, CT 06360

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #1) reviewed for falls, the facility failed to ensure a resident, who was not assessed as an elopement risk, was free from involuntary seclusion, when a Wanderguard device (a bracelet which is a part of a wander management system designed to prevent those at risk for wandering from leaving a protected area) was applied without the resident's consent. The findings include: Resident #1's diagnoses included Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), atrial fibrillation (irregular heartbeat), anxiety disorder and personality disorder. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had intact cognition (Brief Interview for Mental Status (BIMS) of 13), required substantial assistance for bed mobility and was dependent on staff for transfers. Review of the Morse Fall Scale Evaluation dated 4/24/25 identified Resident #1 had a history of falls, was observed with a weak gait (difficulty walking) and overestimates or forgets his/her limits, putting Resident #1 at a high risk for falling. Review of an Elopement Evaluation dated 4/24/25 identified Resident #1 was oriented to person and place, was not exit seeking, had not attempted to elope in the last 30 days and was not at risk for elopement. The Resident Care Plan (RCP) dated 4/25/25 identified Resident #1 as a high risk for falls due to gait/balance problems and incontinence. Interventions included ensuring Resident #1 was wearing appropriate footwear when ambulating or mobilizing in the wheelchair, anticipating and meeting Resident #1's needs and ensuring a safe environment. The RCP did not identify a risk for elopement. A nurse's note dated 5/25/25 at 9:05 PM by RN #1 (3:00 PM to 11:00 PM nursing supervisor) identified Resident #1 fell, and upon assessment, Resident #1 was lying on the ground in front of his/her wheelchair with a laceration to the forehead/hairline with a moderate amount of blood and that pressure was applied to the area. The note identified Resident #1 was alert and at baseline cognition, range of motion to all extremities was within normal limits, and Resident #1 was complaining of a moderate headache. The family and the Advanced Practice Registered Nurse (APRN) were notified, and Resident #1 was transferred to the hospital around 7:10 PM. Review of the facility Accident and Investigation (A&I) report dated 5/25/25 identified that at 6:30 PM, Resident #1 was found outside on the ground near the facility main entrance. Resident #1 leaned forward out of the wheelchair to pick something up from the ground and tumbled out of the chair, hitting his/her head. The A&I identified Resident #1 was on an anticoagulant (a blood thinner that prevents blood clots from forming or growing larger) and sustained a laceration to the scalp/hairline and an abrasion to the bridge of his/her nose. The report identified Resident #1 was educated on spending outdoor time in the facility courtyard rather than the facility main entrance and Physical Therapy would evaluate Resident #1 for the use of a reacher/grabber. Review of hospital documentation dated 5/25/25 identified Resident #1 was evaluated in the ED after he/she was found on the ground outside of the nursing home, had an unknown loss of consciousness and presented with an injury to the forehead and was diagnosed, in part, with a head contusion (a bruise) and a forehead laceration. The facial wound was cleaned and closed with Dermabond (a tissue adhesive used to close wounds, like sutures, but without the need for subsequent removal) and Resident #1 was transported back to the facility. Review of an Elopement Risk Scale dated 5/26/25 identified Resident #1 could communicate and follow instructions, move without assistance while in the wheelchair, had no history of wandering, knew how to return to his/her unit, had no episodes of walking aimlessly and had no diagnosis of dementia. A physician's order dated 5/26/25 directed for a Wanderguard to be intact to Resident #1's wheelchair and for staff to check placement and function every shift. Interview and observation with Resident #1 on 6/9/25 at 10:09 AM identified that on 5/25/25 around dinner time, he/she rolled him/herself in the wheelchair to the receptionist desk to request money from his/her account. Resident #1 reported that when no one was present at the receptionist desk area, he/she decided to go through the main entrance doors, which opened as he/she approached them, to sit outside in the main entrance area. Resident #1 identified that he/she started to read a book and then noticed paper on the ground, so leaned over to pick up the paper and stated, the next thing I knew I was on the ground. Resident #1 indicated he/she slipped out of the wheelchair face first onto the ground. Resident #1 identified he/she did not know what a Wanderguard was, no one discussed the use of a Wanderguard with him/her and he/she never tried to leave the facility without permission. The back of Resident #1's wheelchair was maroon in color, 'Jay J3' model, and was labeled with Resident #1's last name. A Wanderguard was attached to the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #4) reviewed for elopement, the facility failed to ensure a comprehensive care plan was developed for a resident who was at risk for elopement and had a provider ordered Wanderguard (a bracelet which is a part of a wander management system designed to prevent those at risk for wandering from leaving a protected area). The findings include: Resident #4's diagnoses included dementia with behavioral disturbances and adjustment disorder with anxiety. A physician's order dated 5/30/24 directed a Wanderguard be affixed to Resident #4's wheelchair at all times. An Elopement Evaluation dated 12/11/24 identified Resident #4 was exit seeking, oblivious to needs or safety, wanted to go home or leave, had a diagnosis of Alzheimer's disease (a progressive dementia that destroys memory and important mental functions) and was at risk for elopement. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 had severely impaired cognition (Brief Mental Interview for Mental Status (BIMS) score of 3), was dependent on staff for personal hygiene, bed mobility and transfers. The MDS identified wandering behaviors were not present. An Elopement Evaluation dated 3/4/25 identified Resident #4 was not exit seeking, displayed behaviors of wanting to go home, watched others go out the doors, expressed/experienced feelings of fear/anger of abandonment and had a diagnosis of Alzheimer's disease. A nurse's note dated 5/22/25 at 1:42 PM identified Resident #4 continued to tell staff that he/she is going to quit this job and take the bus home. A nurse's note dated 5/23/25 at 12:05 PM identified that family was in to visit and discussed increased confusion related to bed relocation (5/21/25). Resident #4 was looking for his/her friend, wanted to go home to his/her mother and father, and believed people were looking at him/her through the window. A nurse's note dated 5/27/25 at 5:21 PM identified Resident #4 reported he/she was going home with his/her brother because he/she needed to go home to his/her parents. A nurse's note dated 6/2/25 at 12:27 PM identified Resident #4 believed he/she was an employee of the facility, wanted the afternoon off, continued to believe he/she was going home to his/her parent's house and was redirected with little effect. A nurse's note dated 6/4/25 at 12:08 PM identified Resident #4 was sitting in the common area stating he/she was bored, needed to find a new job and that he/she was leaving with his/her spouse to their house in Pennsylvania. Review of the May and June 2025 Medication Administration Record (MAR) identified behavior monitoring for pacing but failed to identify a behavior of exit seeking, wanting to go home or leave the facility, watching others go out of doors, or expressing/experiencing feelings of fear/anger of abandonment. Review of the facility At Risk for Elopement binder, on 6/9/25 at 12:02 PM, which was located at the receptionist desk, identified Resident #4's picture and information identifying he/she was at risk for elopement. Observation of Resident #4 on 6/9/25 at 12:49 PM, identified a Wanderguard intact to the front right of Resident #4's wheelchair. Resident #4 reported that after lunch, he/she was going to work. Interview with RN #2 (MDS Coordinator) on 6/9/25 at 1:29 PM identified she completed the Elopement Evaluation dated 3/4/25 which identified Resident #4 had exit seeking behaviors but was not at risk for elopement. She further identified Resident #4 often had exit seeking behaviors and expressed he/she wanted to leave the facility. Additionally, RN #2 identified she was unaware behavior monitoring did not include exit seeking behaviors to include wanting to go home or leave, watching others go out of doors or expressing/experiencing feelings of fear/anger of abandonment. She identified that since there was a physician's order for a Wanderguard and the Wanderguard was currently in place, staff should have been documenting exit seeking behaviors as part of the facility's behavior monitoring. She identified that she should have discovered the lack of documentation when she completed the comprehensive assessment. RN #2 further identified that any resident who had a Wanderguard should have a care plan in place for elopement with interventions to prevent elopement. Interview with the DNS on 6/9/25 identified Resident #4 was at risk for elopement, the Elopement Evaluation should have identified the elopement risk and an elopement care plan should have been developed. The DNS identified that RN #2 was responsible for the evaluation, the care plan and ensuring behavior monitoring matched actual behaviors. The DNS identified RN#2 should have notified her with any discrepancies. Subsequent to surveyor inquiry, a Resident Care Plan (RCP) dated 6/9/25 identified Resident #4 was at risk for elopement and wandering related to disorientation to place, history of attempts to leave the facility unattended and impaired safety. Interventions included distracting the resident from wandering by offering pleasant diversions, structured activities, food

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #1) reviewed for falls, the facility failed to ensure that a laceration sustained from a fall was treated in accordance with physician's orders. The findings include: Resident #1's diagnoses included Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), atrial fibrillation (irregular heartbeat), anxiety disorder and personality disorder. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had intact cognition (Brief Interview for Mental Status (BIMS) of 13), required substantial assistance for bed mobility and was dependent on staff for transfers. The Resident Care Plan (RCP) dated 5/29/25 identified that Resident #1 had an actual impairment to skin integrity of the face and forehead related to an abrasion and a laceration sustained from a fall. Interventions included following facility protocols for treatment of an injury and monitoring and documenting the location, size and treatment of the skin injury. A nurse's note dated 5/25/25 at 9:05 PM by RN #1 (3:00 PM to 11:00 PM nursing supervisor) identified Resident #1 fell, and upon assessment, Resident #1 was lying on the ground in front of his/her wheelchair with a laceration to the forehead/hairline with a moderate amount of blood and that pressure was applied to the area. The note identified Resident #1 was alert and at baseline cognition, range of motion to all extremities was within normal limits, and Resident #1 was complaining of a moderate headache. The family and the Advanced Practice Registered Nurse (APRN) were notified, and Resident #1 was transferred to the hospital around 7:10 PM. PM. A physician's order dated 6/8/25 directed for the forehead laceration to be cleansed with normal saline, patted dry, bacitracin (a topical antibiotic used to help prevent skin infections from cuts, scrapes and burns) to be applied to the area and covered with a band aid daily and as needed. Observation of Resident #1 on 6/9/25 at 10:09 AM identified a band aid dated 6/7 placed vertically covering an area between both eyebrows. A dark drainage was noted under the band aid. Observation of Resident #1 with the DNS on 6/9/25 at 11:06 AM identified a band aid dated 6/7 placed vertically covering an area between both eyebrows. A dark drainage was noted under the band aid. Review of the June 2025 Treatment Administration Record (TAR) identified that the treatment to Resident #1's forehead was signed off as completed on 6/8/25 by LPN #2. Review of nurse's notes dated 6/8/25 failed to identify documentation related to the forehead dressing. Interview and clinical record review with the DNS on 6/9/25 at 11:09 AM identified that per physician's order the treatment to Resident #1's forehead should have been completed daily on the 3:00 PM to 11:00 PM shift and as needed. Subsequent to surveyor inquiry, the treatment to Resident #1's forehead was signed off as completed in the TAR on 6/9/25 at 11:13 AM. Observation of Resident #1 on 6/9/25 at 11:38 AM identified the band aid to his/her forehead was noted to be clean, dry and intact and was dated 6/9. Interview with LPN #2 on 6/9/25 at 11:49 AM identified that on 6/8/25, she signed off the forehead treatment as administered prior to completing the treatment. She identified that when she went to administer the treatment around 8:30 PM, the resident was already sleeping so she did not assess the area or change the dressing as ordered. She identified she should never sign off orders as administered prior to completing them and that she was in a rush. Re-interview with the DNS on 6/9/25 at 2:47 PM identified that licensed nurses should not sign off orders until they are administered. Although requested, a facility policy for physician's orders and treatment administration were not provided.

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #1) reviewed for falls, the facility failed to ensure the resident was supervised outside of the facility leading to a fall with injury. The findings include: Resident #1's diagnoses included Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), atrial fibrillation (irregular heartbeat), anxiety disorder and personality disorder. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had intact cognition (Brief Interview for Mental Status (BIMS) of 13), required substantial assistance for bed mobility and was dependent on staff for transfers. Review of the Morse Fall Scale Evaluation dated 4/24/25 identified Resident #1 had a history of falls, was observed with a weak gait (difficulty walking) and overestimates or forgets his/her limits, putting Resident #1 at a high risk for falling. The Resident Care Plan (RCP) dated 4/25/25 identified Resident #1 as a high risk for falls due to gait/balance problems and incontinence. Interventions included ensuring Resident #1 was wearing appropriate footwear when ambulating or mobilizing in the wheelchair, anticipating and meeting Resident #1's needs and ensuring a safe environment. A nurse's note dated 5/25/25 at 9:05 PM by RN #1 (3:00 PM to 11:00 PM nursing supervisor) identified Resident #1 fell, and upon assessment, Resident #1 was lying on the ground in front of his/her wheelchair with a laceration to the forehead/hairline with a moderate amount of blood and that pressure was applied to the area. The note identified Resident #1 was alert and at baseline cognition, range of motion to all extremities was within normal limits, and Resident #1 was complaining of a moderate headache. The family and the Advanced Practice Registered Nurse (APRN) were notified, and Resident #1 was transferred to the hospital around 7:10 PM. Review of the facility Accident and Investigation (A&I) report dated 5/25/25 identified that at 6:30 PM, Resident #1 was found outside on the ground near the facility main entrance. Resident #1 leaned forward out of the wheelchair to pick something up from the ground and tumbled out of the chair, hitting his/her head. The A&I identified Resident #1 was on an anticoagulant (a blood thinner that prevents blood clots from forming or growing larger) and sustained a laceration to the scalp/hairline and an abrasion to the bridge of his/her nose. The report identified Resident #1 was educated on spending outdoor time in the facility courtyard rather than the facility main entrance and Physical Therapy would evaluate Resident #1 for the use of a reacher/grabber. RN #3's statement dated 5/25/25 identified at approximately 6:30 PM, he was off duty driving by the facility when he observed Resident #1 sitting outside of the front of the facility in his/her wheelchair. RN #3 indicated he knew Resident #1 to be confused and was concerned Resident #1 was unsupervised, so pulled into the facility and tried to locate a nursing supervisor. He identified that once he located RN #1 and they ran to the main entrance of the facility, Resident #1 was already on the ground, RN #1 started her assessment, and he called the DNS to alert her of the incident at 6:47 PM. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of hospital documentation dated 5/25/25 identified Resident #1 was evaluated in the ED after he/she was found on the ground outside of the nursing home, had an unknown loss of consciousness and presented with an injury to the forehead and was diagnosed, in part, with a head contusion (a bruise) and a forehead laceration. The facial wound was cleaned and closed with Dermabond (a tissue adhesive used to close wounds, like sutures, but without the need for subsequent removal) and Resident #1 was transported back to the facility. Observation of the front entrance of the facility on 6/9/25 at 9:30 AM identified a fairly steep decline down to the parking area. There were approximately ten (10) feet on either side of the main entrance door that was flat before a change in the downwards slope. It did not appear to be safe for residents in wheelchairs to be sitting outside the front entrance. Interview and observation with Resident #1 on 6/9/25 at 10:09 AM identified that on 5/25/25 around dinner time, he/she rolled him/herself in the wheelchair to the receptionist desk to request money from his/her account. Resident #1 reported that when no one was present at the receptionist desk area, he/she decided to go through the main entrance doors, which opened as he/she approached them, to sit outside in the main entrance area. Resident #1 identified that he/she started to read a book and then noticed paper on the ground, so leaned over to pick up the paper and stated, the next thing I knew I was on the ground. Resident #1 indicated he/she slipped out of the wheelchair face first onto the ground. On observation, Resident #1 was noted with a scabbed area to the bridge of his/her nose and a band aid (dated 6/7) placed vertically covering an area between the eyebrows. Resident #1 identified that he/she looked like a racoon last week with bruising surrounding both eyes. Interview with RN #1 (3:00 PM to 11:00 PM nursing supervisor) on 6/9/25 at 10:46 AM identified that on 5/25/25, she was alerted by another staff member (could not recall who) that Resident #1 was sitting unattended outside of the main entrance. She reported that she immediately went to the scene and observed Resident #1 on the ground with a laceration to the forehead and that she applied pressure to control bleeding. RN #1 identified Resident #1 was transferred to the ED for evaluation due to the head strike. RN #1 reported she could not recall if the brakes on the wheelchair were locked and identified she was unsure how Resident #1 got outside or how long he/she was outside. Interview with the DNS on 6/9/25 at 11:09 AM identified Resident #1 should not have been outside the facility main entrance unattended. The DNS identified her investigation discovered NA #2 changed the main entrance door from night mode (door is locked and anyone trying to leave must enter a code to disengage the door and anyone trying to enter must push a buzzer on the outside of the building for staff to manually push a button behind the receptionist desk to open the door) to day mode (door automatically opens when someone approaches to exit or enter the building). She reported that Receptionist #1 left early on 5/25/25 and changed the door to night mode prior to leaving. She identified the receptionist desk is usually staffed until 7:00 PM but she was unsure if staff on all the units were aware there was no staff at the receptionist desk so that residents were supervised accordingly. She was unable to provide statements identifying when Resident #1 was last seen prior to RN #1 observing Resident #1 outside at 6:30 PM and was unable to explain why statements were not obtained from all staff that could have had contact with Resident #1 that evening. The DNS identified that following the 5/25/25 incident, NA #2 was sent home and suspended for three (3) days, staff were educated on the use of the main entrance door afterhours, Resident #1 was educated to use the courtyard if he/she wishes to go outside and PT was requested to evaluate Resident #1 for the use of a reacher/grabber. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Receptionist #1's timecard identified that she worked from 9:30 AM to 4:15 PM on 5/25/25. Review of facility education documentation dated 5/25/25 identified that, at no time, should the main entrance doors be set to day mode without an attendant at the desk, and if there is no receptionist on duty, the door must remain on night mode and visitors must be let in and out by the button at the desk only. Interview with OT #1 (Rehab Manager) on 6/9/25 at 1:07 PM identified Resident #1 was receiving Occupational Therapy services on 5/25/25, he/she was not safe to be outside unattended on 5/25/25 and he/she required supervision while in the wheelchair due to cognition and poor safety awareness. He identified Resident #1 was not safe to be sitting outside the main entrance of the building as it was a downwards hill and Resident #1 did not have sufficient lower extremity strength to stop him/herself if the wheelchair was on an uneven surface or if it started to roll. OT #1 further indicated Resident #1 required a Hoyer (mechanical) lift for transfers for years due to lower extremity weakness. Interview with NA #2 on 6/9/25 at 3:04 PM identified that on 5/25/25 she was working on the North Unit, which was the unit closest to the main entrance. She reported that Receptionist #1 left early, and that she (NA #2) was repeatedly interrupted by the front door buzzer while performing evening care for residents. She reported she felt like she was putting the residents at risk for falls by having to leave them to open the front door, so she changed the front door from night mode to day mode so people could enter and exit through the main entrance freely rather than interrupt her. NA #2 identified she should not have touched the settings on the door and was suspended for three (3) days following the incident. Although attempted, interviews with NA #1, LPN #1 and RN #1 were not obtained. Although requested, facility policies for locking of the main entrance door and criteria for allowing residents to be outside of the building on facility grounds unattended were not provided.